Exhibit P

10-12-04

Record Services
Scanner Separator Sheet

PNO

075245678

Application

Please Return With Archived Folder
** Do Not Discard! **

Application for Life Insurance

This application is to: ❑ John Hancock Life Insurance Company or
❑ John Hancock Variable Life Insurance Company
which will sometimes hereinafter be referred to as "the Company" and "John Hancock".

Instructions:

1. Please print all answers legibly in black ink.
2. Please complete only one "Page 2", depending on the plan applied for.
3. Any change or deletion must be initialed by the Proposed Insured or Applicant.
4. Part B must be completed on all people proposed for coverage unless they are to be medically examined.

Please indicate type of case, complete the necessary section, and enter/send application where indicated.

Type of Application	Complete These Sections	Enter/Send Application
❑ **New Life Insurance Policy** **Replacement** **Pension Trust**	Part A Part B *(if Nonmedical application)* Agreement and Signatures Authorization Page 8 Pages 9-13 *(if applicable)*	Enter case into ELUS (Date entered: ___/___/___) Send to Underwriting
❑ **Term Conversion** (of John Hancock term policies and riders)	Part A *(except Questions 4, 7, and 9 of Box A, Box M, and Questions 1, 2, 4, and 5 of Box N)* Part B *(if excess amount / riders applied for)* Agreement and Signatures Authorization *(if excess amounts / riders applied for)* Page 10 Pages 9-13 *(if applicable)*	Enter case into ELUS (Date entered: ___/___/___) Send to Underwriting
❑ **Rider Addition** (to existing policy) **Increases in Amount** (FlexV, MVL Plus, MVL Edge, UL) **Option Change 1 to 2** (FlexV, MVL Plus, MVL Edge, UL)	Part A *(Boxes A, D, I, J, M, N, O, and S only)* Part B Agreement and Signatures Authorization Page 5 Pages 10-13 *(if applicable)* *Use Boxes I and J on Page 2*	Send to Underwriting
❑ **Change in Rating**	Part A *(Box A and S only)* Part B Agreement and Signatures Authorization Sales Credit	Send to Underwriting
❑ **Contractual Changes** (e.g., Exchange of Existing Policy, Plan Changes, Amount Reductions) **Option Change 2 to 1** (FlexV, MVL Plus, MVL Edge, UL)	Part A *(Box S only)* Part B *(if changing to Lower Premium Plan)* Agreement and Signatures Authorization *(if underwriting required)* Sales Credit	Send to Coverage Changes

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

John Hancock

John Hancock Financial Services

PLEASE COMPLETE ANY SECTION BELOW THAT PERTAINS TO THIS CASE

POSITIVE ID REQUIRED

Underwriting Requirements

Please indicate which underwriting requirements have been ordered.

	Proposed Insured	Spouse
Paramedical or Medical Exam	❑	❑
APS in lieu of exam	❑	❑
APS	❑	❑
Blood Sample/Urinalysis	❑	❑
Inspection Report	❑	❑
EKG	❑	❑
Oral Fluid Test	❑	❑
Other	❑	❑

1035 Exchange

This checklist is meant to serve as a quick reference for 1035 Exchanges.
For more detail, please refer to your Market Conduct Manual.
Policyholder Replacement forms (PRQ) are needed for either Internal or External 1035 Replacements.
Is an illustration reflecting a 1035 Exchange attached?
Replacement forms need to be dated on or before this application date.

1035 Internal Replacement	
Are the Replacement Forms required by the applicable state attached?	❑
Is the original policy or policies being replaced attached?	❑
Is the completed Surrender Form attached?	❑
Is Form 473R *Please Transfer My Money* (one per policy) attached?	❑
Have Application questions 3a and 3b, Page 4, Box N been completed?	❑
Does the illustration include the 1035 Exchange adjusted 7-pay premium worksheet?	❑
If the new policy is a Modified Endowment (MEC), has page 11 of the application been signed?	❑

1035 External Replacement ***May Not Be Prepaid***	
Are the Replacement Forms required by the applicable state attached?	❑
Is the external policy or policies being replaced attached?	❑
Form 17010 *Exchange Of Life Insurance Under Internal Revenue Code Section 1035(a)* (one per policy) attached?	❑
Have Application questions 3a and 3b, Box N been completed?	❑
Does the illustration include the 1035 Exchange adjusted 7-pay premium worksheet?	❑
If the new policy is a Modified Endowment (MEC), has page 11 of the application been signed?	❑

MILITARY CASES

1. Permanent U.S. Residence _____
2. Pay Grade _____ 3. Soc Sec. or ID# of person entering allotment _____
4. Anticipated date of discharge or retirement _____month_____year

JUVENILE OR CHILDREN'S INSURANCE

1. Did you see the Proposed Insured/Child? ❑ Yes ❑ No (If not, explain on additional sheet of paper.)
2. With whom does Proposed Insured/Child reside? Name _____
   Relationship to Proposed Insured/Child _____
3. Is Proposed Insured in school? ❑ Yes (Grade _____) ❑ No
4. Amount of life Insurance in force or applied for on the: Father $ _____ Mother $_____
5. Are all siblings under age 15 insured for at least this amount? ❑ Yes ❑ No (If not, explain on additional sheet of paper.)

ALTERNATE PREMIUM PAYMENT PLAN POLICIES (TRADITIONAL ONLY)

1. Alternate premium payment plan testing should begin at year _____ *(Same year should be indicated on page 9.)*
2. Has the Policyowner read and signed page 9 of this application? ❑ Yes ❑ No

MODIFIED ENDOWMENTS

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1. Does the sales illustration show that the policy applied for is a Modified Endowment Contract (MEC)? ❑ Yes ❑ No
2. If yes, has the Policyowner signed the MEC Acknowledgment Form on Page 11? ❑ Yes ❑ No

9054612 J146476 **Part A Statements to the Company's Agent**

A. PROPOSED INSURED

1. Name of Proposed Insured:
   First - Bang MI ____
   Last Lin
2. Sex ☑ Male ☐ Female
3. Date of Birth 8/6/69
4. Place of Birth Taipei (STATE) Taiwan (COUNTRY, IF NOT U.S.A.)
5. Soc. Sec. Number 085 - 66 - 4601
6. Driver's License #: A9644172 State: CA
7. Height 5 ft. 8 in. 8. Weight 170 lbs.
9. Occupation Self Employed
   Military Pay Grade (if applicable) __
10. Address 7 Green Hollow (STREET ADDRESS)
    Irvine (CITY) CA (STATE) 92620 (ZIP)
11. Home Phone (714) 734 - 9029
12. Work Phone (949) 756 - 2772
13. Best time and place for Underwriting to call (in Proposed Insured's local time zone) ____
14. Does the Proposed Insured smoke cigarettes or use any other tobacco product, i.e., cigars, pipes, snuff, chewing tobacco, etc.? ☐ Yes ☑ No
    If Yes: ____ (product) ____ (frequency)
    If No, is the Proposed Insured a former tobacco user? ☐ Yes ☑ No
    If Yes: ____ (product) ____ (date last used)

B. BENEFICIARY OF PROCEEDS PAYABLE IN THE EVENT OF THE INSURED'S DEATH

PRIMARY: Please indicate full name and relationship to the Proposed Insured.
Jean Lin wife

CONTINGENT: Please indicate full name and relationship to the Proposed Insured.
Aagus Lin Chelsey Lin 50/50.
Proceeds at death of any person other than the Proposed Insured shall be paid as provided in the applicable benefit provision. The right is reserved to the Owner to change the Beneficiary of any proceeds.

C. COMPLETE THIS BOX ONLY IF OWNER IS NOT THE PROPOSED INSURED

1. Owner Name (First, MI, Last) or name of trust or corp.
   (if more space is needed, use Special Request box and check here ☐)
   Jean Lin
2. Soc. Sec. Number 128 - 64 - 5329
   (or Tax ID Number ____)
3. Occupation Partner
4. Relationship to Proposed Insured
   wife
5. Date of Birth 5/19/71
6. Address 7 Green Hollow (STREET ADDRESS)
   Irvine (CITY) CA (STATE) 92620. (ZIP)
7a. (If PI is under age 15) Contingent Owner name and relationship to Proposed Insured (if none, leave blank) ____
7b. Contingent Owner Age ____

D. COMPLETE THIS BOX ONLY IF SPOUSE, APPLICANT OWNER, OR CHILDREN'S RIDERS DESIRED

1. Please give the following information for all (other than Proposed Insured) being proposed for insurance, or Applicant Owner if Applicant Waiver is applied for. If Children's Insurance is applied for, give names of Proposed Insured's children, adopted children, and stepchildren under age 15. If any child under age 15 is omitted, give name and explain why in Box 5 on Page 5.

First Name	MI	Last Name	D.O.B.	Height (ft./in.)	Weight (lbs.)	Relationship to Proposed Insured	Present Total Life Insurance
			/ /				
			/ /				
			/ /				
			/ /				

2a. Spouse's Driver's License No. ____ State ____ Military Pay Grade (if applicable) __
2b. Spouse's Soc. Sec. Number ____ - ____ - ____ 3. Spouse's Occupation ____
4. Does the Spouse smoke cigarettes or use any other tobacco product, i.e., cigars, pipes, snuff, chewing tobacco, etc.?
   ☐ Yes ☐ No If Yes, product and frequency? ____ Product ____ Frequency
   If No, is the Spouse a former tobacco user? ☐ Yes ☐ No
   If Yes: product and date last used: ____
5. Spouse's Place of Birth: State: ____ Country, if not USA: ____

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PLEASE COMPLETE THIS PAGE IF **TRADITIONAL** or **TERM** IS DESIRED

E. PLAN

- ☐ Modified Premium Whole Life
- ☐ Level Premium Whole Life
- ☒ 10/15/20/25/30 (circle one) Year Level Premium Term
- ☐ Indeterminate Premium Yearly Renewable Term: Level
- ☐ Indeterminate Premium Yearly Renewable Term: Decreasing
  Interest Rate _____%; Term _____ years
- ☐ Other (specify) _____

F. SUM INSURED

$ 1,000,000

G. PAYMENT DETAILS

1. Premium billing interval
   - ☒ Annual ☐ Semiannual
   - ☐ Quarterly ☐ Monthly *(automatic deduction)*
   - ☐ Employee Consultation (Case #_____)
   - ☐ Other

2. Do you elect to have overdue premiums automatically paid, if and when applicable and available, by:
   - a. Dividend values? ☐ Yes ☐ No
   - b. Policy value loan? ☐ Yes ☐ No

H. DIVIDEND OPTION ELECTION (Whole Life only. If AIP Rider is elected in Box I below, do not choose a dividend option.)

Select one of the 15 options in this box for Whole Life only. THESE OPTIONS ARE NOT AVAILABLE IF AIP RIDER IS ELECTED - ONLY OPTIONS "V" OR "LV" ARE AVAILABLE AND MUST BE SELECTED IN BOX I BELOW.

- ☐ A. Taken in cash
- ☐ B. Applied to premium
- ☐ C. Left on deposit
- ☐ D. Buy paid-up insurance
- ☐ LA. Levelize premium, balance in cash
- ☐ LC. Levelize premium, balance left on deposit
- ☐ LD. Levelize premium, balance to buy paid-up insurance
- ☐ LI. Levelize premium, balance to repay loan and then buy paid-up insurance
- ☐ BC. Applied to premium, balance left on deposit
- ☐ BD. Applied to premium, balance to buy paid-up insurance
- ☐ BI. Applied to premium, balance to repay loan and then buy paid-up insurance
- ☐ EA. Buy one-year term, balance in cash
- ☐ EB. Buy one-year term, balance to reduce premium
- ☐ EC. Buy one-year term, balance left on deposit
- ☐ ED. Buy one-year term, balance to buy paid-up insurance

I. RIDERS ON PROPOSED INSURED

- ☐ Accidental Death Benefit $ _____
- ☐ YRT Level Death Benefit $ _____
- ☐ YRT Decreasing Death Benefit $ _____
  Interest Rate_____%; Term_____ years
- ☐ Additional Insurance Protection (AIP)
  Premium $_____ Face amount $_____
  Optional Lump Sum $ _____
  - ☐ AIP Levelized Premium Option
  - ☐ AIP Cost Recovery Option; _____ years, _____%
  - ☐ AIP Increase Option; _____ years, _____%

Dividend Option Election for AIP rider: (choose one)
- ☐ V. Funds AIP Rider
- ☐ LV. Levelize premium, balance to fund AIP Rider

- ☐ Paid-Up Insurance (PUI)
  - ☐ Lump Sum Payment (Option 1) $ _____
  - ☐ Level Annual Premium (Option 2)
    $ _____ per year for _____ years
  - ☐ Modified fill-in premium for 5 years (Option 3)
- ☐ Living Care Benefit (Accelerated Death Benefit)
- ☐ Disability Waiver of Premiums
- ☐ Insurance of Insurability, Purchase Limit $ _____
- ☐ Other Available Riders (please specify) _____

J. RIDERS ON OTHER THAN PROPOSED INSURED

(Please be sure info on any person proposed for insurance is on Page 1, Box D.)

- ☐ Children's Insurance $ _____
- ☐ YRT Level on Spouse $ _____
- ☐ YRT Decreasing on Spouse $ _____
  Interest Rate _____%; Term _____ years

- ☐ Applicant's Disability Waiver of Premiums
- ☐ Other Available Riders (please specify) _____

THIS PAGE MUST BE COMPLETED FOR ALL VARIABLE PRODUCTS

E. PLAN

Choose One:

- ☐ Scheduled Premium Variable Whole Life Insurance (FlexV)
- ☐ Other _____
- ☐ Medallion Variable Universal Life Plus (MVL Plus)
- ☐ Medallion Variable Universal Life Edge (MVL Edge)

K. VARIABLE INVESTMENT OPTIONS

Percentages must be Whole and Total 100%

Large Cap Stock Funds
- _____ % Equity Index
- _____ % Managed
- _____ % Earnings Growth
- _____ % Large Cap Value
- _____ % Large Cap Growth

Large/Mid Cap Stock Funds
- _____ % Fundamental Value
- _____ % Growth & Income

Mid/Small Cap Stock Funds
- _____ % Small/Mid Cap CORE
- _____ % Small/Mid Cap Growth

Small Cap Stock Funds
- _____ % Small Cap Emerging Growth
- _____ % Small Cap Growth

International Stock Funds
- _____ % International Equity Index
- _____ % International Opportunities
- _____ % Emerging Markets Equity
- _____ % Overseas Equity

Sector Funds
- _____ % Real Estate Equity

Fixed Income/Bond Funds
- _____ % Short-Term Bond
- _____ % Bond Index
- _____ % Active Bond
- _____ % High Yield Bond
- _____ % Global Bond
- _____ % Money Market
- _____ % Fixed Account

Available To MVL Plus/Edge, VEP Plus/Edge & MEVL I & III Applicants Only
- _____ % Large Cap Aggressive Growth
- _____ % Fundamental Growth
- _____ % Small Cap Value
- _____ % Large Cap Value CORE
- _____ % AIM V.I. Premier Equity
- _____ % AIM V.I. Capital Development
- _____ % Fidelity VIP Contrafund
- _____ % Fidelity VIP Overseas
- _____ % MFS Investors Growth Stock Series
- _____ % MFS Research Series
- _____ % Janus Aspen Worldwide Growth
- _____ % Financial Industries
- _____ % Janus Aspen Global Technology
- _____ % Health Sciences
- _____ % Total Return Bond
- _____ % Mid Cap Value

***Liquidity restrictions apply when allocating funds to the Fixed Account**

1. Have you received a prospectus for the policy applied for? (If YES, Prospectus Date: _____) ☐ Yes ☐ No
2. Do you understand that the amount of Death Benefit above any Guaranteed Minimum Death Benefit and the entire amount of the Account Value may increase or decrease depending on investment experience? ☐ Yes ☐ No
3. Is the policy and allocation of subaccounts in accord with your insurance objectives and your anticipated financial needs? ☐ Yes ☐ No
4. Have you received an illustration of benefits based on your Planned Premium? ☐ Yes ☐ No

TELEPHONE LOAN OPTION

I direct the Company to act upon telephone instructions from the owner (a trustee, if the owner is a trust, or an authorized business official, if the Owner is a business entity) to process policy loans, subject to the provisions of the policy, and any other requirements.

☐ Yes ☐ No

TELEPHONE TRANSFER AUTHORIZATION

By checking the "yes" box below, I/We direct the Company to act upon telephone instructions from the Owner (a trustee, if the Owner is a trust, or an authorized business official, if the Owner is a business entity) and my/our registered representative, if applicable, to change future payment allocations and/or transfer existing funds among the investment options, subject to the terms of the telephone transfer provision as described in the current prospectus for the policy.

☐ **Yes If yes, please check one:** ☐ **Owner(s) and Registered Representative** ☐ **Owner(s) only**

☐ **No**

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M. UNDERWRITING INFORMATION ("Any person" means any person being proposed for insurance on this Part A.)

1. Has any person done in the past three years, or intend to do any:
   a. flying except as a passenger on regularly scheduled airlines? (If yes, please complete aviation questionnaire.) ☐ Yes ☒ No
   b. skin/scuba diving, parachuting, motorized racing, or other hazardous sports? (If yes, please complete avocation questionnaire.) ☐ Yes ☒ No
2. In the past five years, has any person been convicted of reckless driving or driving under the influence or had a driving license suspended or revoked? ☐ Yes ☒ No
3. In the past three years has any person been convicted of two or more motor vehicle moving violations? ☐ Yes ☒ No
4. In the past 10 years has any person been convicted of or incarcerated for the violation of any criminal law (unless later acquitted), are any criminal charges now pending against any person, or is any person currently on probation? ☐ Yes ☒ No
5. Does any person intend to reside or travel outside the U.S. or Canada? ☐ Yes ☒ No

If any of questions 2-5 are answered "yes", please explain: _____

N. OTHER INSURANCE / REPLACEMENT INFORMATION

1. Give information indicated as to all insurance in force on any person proposed for insurance, including term riders.

Company	Issue Year	Plan	Amount	ADB Amount	Business Insurance?
Mut Life	1998		500,000		☐ Yes ☒ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

2. Is any other insurance application now pending or contemplated on the life of any person proposed for insurance? ☒ Yes ☐ No
   If yes, which person(s)? Insured
   What company(ies)/amounts? WRL

3a. Is the insurance applied for intended to replace or change any life insurance or annuity now in force on any person proposed for insurance? (If yes, give writing company of insurance being replaced, policy number, and insurance amount.) ☐ Yes ☒ No

Company	Policy #	Amount	Company	Policy #	Amount

3b. Check this box if this case is a 1035 exchange. ☐ *(Please refer to inside front cover for 1035 Exchange Guidelines.)*

4. Is Disability Insurance with Provident or Long Term Care Insurance with the Company currently being applied for?
   ☒ No ☐ Yes, DI (Date of application _____) ☐ Yes, LTC (Date of application _____)

5. Has any application for life, disability, or health insurance on any person being proposed for insurance ever been declined, postponed, or modified? (If "Yes", give most recent company, including John Hancock.) _____ ☐ Yes ☒ No
   COMPANY APPROXIMATE DATE

O. PLEASE COMPLETE THIS BOX ONLY IF ADVANCE PAYMENT IS BEING MADE

1. How much advance payment is included with this Part A? $ _____
   (Write check to John Hancock Life or John Hancock Variable Life, as appropriate. 1035 external replacements may not be prepaid.)

P. CUSTOM DATING (optional)

If no other date request is indicated, our regular dating practices will apply.

❑ Back date to save age ❑ Date of Issue _____ / _____ / _____

(FlexV Date of Issue may not be earlier than the Part A date.)

R. CONVERSION DETAILS Note: Complete this box only for conversion of Term Insurance, Children's Insurance, or Purchase Options (1 of 1, SPB, PPB).

1. ❑ This is a ❑ Full ❑ Partial Term Conversion from:

a. Policy Number	Conversion Type	Amount Converted	Amount Remaining In Force
# _____	Base Policy Amount		
	_____ Rider		
	_____ Rider		
b. Policy Number	**Conversion Type**	**Amount Converted**	**Amount Remaining In Force**
# _____	Base Policy Amount		
	_____ Rider		
	_____ Rider		

2. ❑ Conversion of Children's Insurance from Policy #_____

3. ❑ This is an election under ❑ 1 of 1 ❑ SPB ❑ PPB from Policy # _____

❑ Regular Purchase Date, **OR** ❑ Alternate Purchase Date because of _____ on _____ / _____ / _____

4. Is Insured now totally disabled, or is Insured receiving any payments for sickness or injury? ❑ Yes ❑ No

(If yes, give details in Box S below.)

S. SPECIAL REQUESTS

❑ Please change Answer _____ in Box _____ on Page _____ of this Part A to read:

_____

_____

❑ Conversion - Benefits Carried Over ❑ Conversion - Preferred Requested

❑ Contractual Change Request Please change Policy Number _____ as follows:

_____

_____

_____

❑ Change Planned Premium, if applicable, for above contractual change. (FlexV, MVL, UL only)

❑ Other special requests:

_____

_____

_____

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COMPLETE FOR NON-MEDICAL APPLICATIONS ONLY

Please give full details below for every "Yes" answer to Questions 1-6 below as to each person proposed for insurance, who is referred to below as "any person". **Be sure to include the names/addresses of any treatment providers.**

1. Has any person ever been treated for or had any known indication of disease of the heart or blood vessels, chest pain or high blood pressure, hypertension, stroke, paralysis, diabetes, tumor, cancer, convulsions, kidney disease, high cholesterol, gastro-intestinal disease, mental or psychiatric disorder, lung or respiratory disease, or blood disorder (excluding HIV)? ☐ Yes ☑ No
2. Has any person had or ever been diagnosed or treated by a physician or other medical practitioner for Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☑ No
3. Has any person ever received counseling or treatment regarding the use of alcohol, drugs, illegal drugs, or used any illegal drug or controlled substance? ☐ Yes ☑ No
4. Other than indicated above, within the past 5 years has any person
   a) been admitted to a hospital or other medical or rehabilitation facility? ☐ Yes ☑ No
   b) consulted or been treated by a physician, or had a medical exam or checkup? ☐ Yes ☑ No
5. Has either parent of any person died as a result of coronary artery disease or cancer before the age of 60? ☐ Yes ☑ No
6. Has any sibling or any person suffered from coronary artery disease? ☐ Yes ☑ No
7. Is any person currently taking any prescription drug? ☐ Yes ☑ No
   If yes, which person? ______
   What drug? How frequently? ______
8. If any person has a personal physician, please enter name, address, and details below. Otherwise leave blank.

FIRST NAME ______ MI ______ LAST NAME ______

STREET ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

Date last seen: ______ Reason(s) last seen: ______

Details to "yes" questions.

Question No. ______
Name of person ______
Condition ______
Date of onset ______ Last occurrence ______
Treatment/medication, if any ______
Names/addresses of physicians/hospitals providing treatment
______

Question No. ______
Name of person ______
Condition ______
Date of onset ______ Last occurrence ______
Treatment/medication, if any ______
Names/addresses of physicians/hospitals providing treatment
______

Question No. ______
Name of person ______
Condition ______
Date of onset ______ Last occurrence ______
Treatment/medication, if any ______
Names/addresses of physicians/hospitals providing treatment
______

Question No. ______
Name of person ______
Condition ______
Date of onset ______ Last occurrence ______
Treatment/medication, if any ______
Names/addresses of physicians/hospitals providing treatment
______

Please record any additional details on a separate piece of paper.

JH 0160

AGREEMENT AND SIGNATURES

A. The statements and answers on pages 1 through 6 of Part A and Part B of the attached application are, to the best of my knowledge and belief, complete, true, and correctly recorded. All statements and answers are representations and not warranties, and with all Parts B of the attached application will form the basis for and be a part of any new policy or additional benefit provision issued on this application.

B. Coverage will take effect as provided in and subject to the terms and conditions of Conditional Temporary Insurance Agreement Form 156-COMBTIA-99 bearing the same date and number of this Part A if: (1) an advance payment of at least the Minimum Temporary Insurance Premium is made with this Part A which satisfies the requirements of such Conditional Temporary Insurance Agreement; and (2) the amount applied for in this and all other applications now pending in John Hancock Life Insurance Company and the John Hancock Variable Life Insurance Company does not exceed $1,000,000 life insurance.

C. If the applicant has a right to have the new policy issued as requested without completing any Part B, the new policy will take effect as of its Date of Issue, provided the initial payment has been received with this application.

D. In cases other than those described in B and C above, any new policy or benefit provision will take effect as of the Date of Issue of the policy, but: (1) only on delivery to and receipt by the Applicant of the policy and payment of the minimum initial premium thereon and (2) only if at the time of such delivery and payment each person proposed for insurance in Parts A and B of this application is living and has not consulted or been examined or treated by a physician or practitioner since the latest Part B pertaining to such person was completed.

E. No agent or medical examiner is authorized to make or discharge policies or waive or change any of the conditions or provisions of any application, policy, or receipt, or to accept risks or pass on insurability. Any such unauthorized action is not notice to or knowledge of the Company. A medical examiner is not an agent of the Company.

Provisions F and G apply only to variable products

F. All benefits, payments, and values, including the Death Benefit and Account Value, under any policy issued which is based upon the investment experience of a separate investment account may increase or decrease in accordance with the investment experience of the separate investment account and are not guaranteed as to fixed dollar amount. The Account Value may even decrease to zero.

G. A prospectus for the policy applied for has been given to the Proposed Insured and/or to the Applicant.

Provisions H, I, J, K, and L apply if the policy applied for is a term conversion or purchase option.

H. The new policy will be a new, separate contract. If the new policy is issued in exchange for the original insurance, all liability of the Company under the original insurance will cease when the new policy takes effect. Until the new policy is issued, coverage will still be in force under the original policy. Coverage under the new policy will take effect as indicated in Paragraph C above.

I. The application for the original insurance, unless such insurance is now incontestable, and the application for each additional benefit provision which is to be retained as specified on page 2 of this Application, unless such provision is now incontestable, will also form a basis for and be a part of the new policy.

J. If the original policy or benefit provision is being exchanged and is subject to an assignment, the new policy will be subject to the same assignment unless it is discharged or, in the case of a policy loan assignment, unless the indebtedness has been repaid.

K. If the new policy is issued in exchange for the original policy, any nonforfeiture option election applicable to the original policy will be applicable to the new policy, if available, unless otherwise requested in writing.

L. Ownership and control of any policy issued on the attached application will be determined by the terms of the new policy.

All statements and answers in this application are representations and not warranties and to the best of my knowledge and belief, are true and complete. I certify under the penalty of perjury that the Owner's Taxpayer Identification Number on page one is correct and complete. I assent to this application.

X _____
Signature of Proposed Insured, if other than Applicant and age 15 or over

Applicant's Signature

Signature of Proposed Insured's Spouse, if proposed for insurance

Witness (Agent must witness where required by law)

X _____
Policyowner, Assignee or Irrevocable Beneficiary (Signature required only for exchange of policy or benefit provisions)

Irvine CA
City or Town State

on 9/17/04 20__
Date

JH 0161

TO BE COMPLETED IN EVERY CASE. DO NOT DETACH.

JOHN HANCOCK LIFE INSURANCE COMPANY JOHN HANCOCK VARIABLE LIFE INSURANCE COMPANY

Authorization and Acknowledgment

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge regarding each of the undersigned and any children of the undersigned if proposed for insurance to give to the Company or its affiliates and reinsurers any such information, including information concerning every condition for which each has been under observation or treatment, including if the information specified contains information related to treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions, the history obtained, physical and laboratory findings, diagnosis and treatment. I hereby authorize the Company to release any records or other information in their possession regarding each of the undersigned, and any children of the undersigned if proposed for insurance, to the JH Networking Insurance Agency, Inc., which may use this information in its efforts to secure insurance coverage for substandard risks with other insurance companies, a list of which is available upon request.

I acknowledge receipt of the Federal Fair Credit Reporting Act notice which contains on the reverse side a notice concerning the Medical Information Bureau.

A copy of this authorization is as valid as the original. This authorization is valid for 24 months from the date of the Proposed Insured's signature.

Signature of Proposed Insured's Spouse, if proposed for insurance

Signature of Proposed Insured, if age 15 or over, or Applicant if Proposed Insured is under age 15

Name of Proposed Insured, if under 15 (please print)

Date 9/17/04

AUTHORIZATION FOR AUTOMATIC DEDUCTION PLAN

I authorize the Company to deduct the premiums for the policy applied for on this application from the bank account listed below. I understand that the deduction will take place on or about the day I have selected below.

Proposed Insured's Name _____ Policy Number _____

Name of Bank _____

Routing/Transit number _____ Account number _____

Draft Initial Payment? (Yes / No) Account type (CHECKING or SAVINGS) _____

Draft Date: _____ (the Draft Date may not be the 29th, 30th or 31st). If Draft Date is left blank, the default Draft Date will be the Issue Date.

Name(s) of Depositor(s) _____ _____

Signature(s) of Depositor(s) _____ _____

On Variable policies with an illustration showing an anticipated dump in premium, if you elect to draft the initial payment and the required dump in has not been applied, the required premium will be drafted.

JH 0162

REQUEST TO USE POLICY VALUES TO PAY PREMIUMS (TRADITIONAL ONLY)

I elect to have my policy premiums paid by non-guaranteed policy values, if sufficient, beginning in the year selected below. This payment option is possible only if future dividend and/or cash values are large enough to pay the required premium which is due each year. Lower dividends, policy loans, or withdrawals taken from the policy could cause additional premiums to be required. The Company recommends that I review illustrations using various dividend projections to understand how actual dividend experience may affect the policy values and payment schedule.

ALTERNATE PREMIUM PAYMENT PLAN COMMENCEMENT

I elect to have the Alternate Premium Payment Plan begin in policy year_____. This year is based upon an illustration at issue assuming (circle one) ***Current*** or ***Reduced*** dividend scale (Indicate reduction from current scale by_____% interest).

At the beginning of the year indicated above, the Company will test my policy using the dividend scale in effect at the time. If the test shows that projected policy values are adequate to pay all future premiums based on that current dividend scale, my premiums will be eligible to be paid from policy values. If the test shows that projected policy values are not adequate to pay all future premiums, the test will continue to be repeated each year. Policy premiums will be eligible to be paid in the earliest year when values are shown to be sufficient to pay all future premiums.

The Company will notify me in writing when my policy becomes eligible for this payment option. At that time I may choose to allow the Alternate Premium Payment Plan to begin, or I may choose to continue to pay premiums in cash to further build my policy's values.

ALTERNATE PREMIUM PAYMENT PLAN MECHANICS

When I elect the Alternate Premium Payment Plan, policy values will be applied in the following order to pay the premium amount due:

1. Dividends declared for payment on the policy anniversary;
2. Amounts accumulated, if any, of dividends on deposit;
3. Surrender value of any paid-up insurance.

CHANGES IN ALTERNATE PREMIUM PAYMENT PLAN STATUS

Any of the following may affect my future eligibility to begin or continue to pay my premiums from policy values:

- Partial surrenders of paid-up additions or paid-up insurance;
- Policy loans;
- Actual dividends which are less than those projected (dividends are not guaranteed);
- Changes in the dividend option;
- Any requested change to the policy that affects the premium.

The Company strongly recommends that I review policy illustrations using various dividend assumptions to see the impact of lower than current dividend scales and the impact on the Alternate Premium Payment Plan.

If at any time, policy values are not sufficient to pay the amount of premium then required, no policy values will be applied to pay premiums, and billing for the required premium will resume. I will be notified if that occurs.

ACKNOWLEDGMENT

I understand that I have the opportunity to use non-guaranteed policy values to pay required premium payments. I understand that the year indicated above represents the year to begin testing for the Alternate Premium Payment Plan, and that this year is not guaranteed and dependent on policy values actually available at the time of the test and the dividend scale then applicable to my policy.

Signature of Proposed Insured, if other than Applicant and age 15 or over	Applicant's Signature
Signature of Proposed Insured's Spouse, if proposed for insurance	Witness (Agent must witness where required by law)
Policyowner, Assignee of Irrevocable Beneficiary (Signature required only for exchange of policy or benefit provisions)	City or Town State

on _____ , _____
Date

SALES CREDIT FOR APPLICATION

AGENCY NAME	ORD. CODE	CITY TAX	GAMA INITIALS
WFG Heartland	128		JAG

SALES/STAFF MGR. NAME	NUMBER 1	MARKETING REP. NAME	CONTRACT	MARKTG REP.#	MARKTG TERR.#	%
Johnson Leung	131305	Johnson Leung	RE	194450		100
B. Warfield	NUMBER 2	MARKETING REP. NAME	CONTRACT	MARKTG REP.#	MARKTG TERR.#	%
SALES/STAFF MGR. NAME	NUMBER 3	MARKETING REP. NAME	CONTRACT	MARKTG REP.#	MARKTG TERR.#	%

SUPPLEMENTARY UNDERWRITING INFORMATION (REQUIRED FOR ALL CASES)

1. Please provide the Proposed Insured's addresses for the last two years.

Time at Residence	Street Address	City/Town	State	ZIP
8 yrs. 2 mos.	See Part A, Page 1			
____ yrs. ____ mos.				
____ yrs. ____ mos.				

2. Please provide the Proposed Insured's employment details for the last two years.

Time Employed	Employer Name	Street Address	City/Town	State	ZIP
____ yrs. ____ mos.	Same as above				
____ yrs. ____ mos.					
____ yrs. ____ mos.					

3. How long have you known the Proposed Insured? 3 yrs

4. Are you related to the Proposed Insured? ☐ Yes (relationship) _____ ☒ No

5. Has Proposed Insured been known by any other names within the last ten years? ☐ Yes (what names) _____ ☒ No

6. (For contractual changes) To the best of your knowledge, is the Proposed Insured in good health? ☒ Yes ☐ No

From my knowledge and investigation, the Proposed Insured is of temperate habits and good moral character, and I know nothing affecting the insurability of the Proposed Insured not stated hereon, and I recommend his/her acceptance without qualification.

Proposed Insured interviewed by me on 9/17/04

The Federal Fair Credit Reporting Act notice and any state required disclosures have been delivered as required.

Sales Manager/Staff Manager/Marketing Representative

AGENT

Is the insurance applied for a replacement according to the Company's current replacement rules? ☐ Yes ☐ No

This application, including suitability information has been reviewed by me and I recommend the product proposed and the use.

General Agent/Agency Manager/Designated Compliance Specialist

REQUEST FOR AUTOMATIC DEDUCTION PLAN: PLEASE SEND TO AUTOMATIC COLLECTIONS

Please make sure that the Automatic Deduction Authorization on Page 8 is completed and signed.

Name of Insured _____ Policy Number _____

1. All cases: please check one of a or b

☐ a. This is a new Automatic Deduction account. Please attach either 1) a blank voided check; 2) a copy of the Payor's check for the initial premium; or 3) a copy of a cancelled check.

Note: Do not send voided check until policy is issued.

☐ b. This is an addition to an existing Automatic Deduction account, Control Number: _____

2. Required for FlexV, Medallion Variable Universal Life, and all Universal Life cases

Please place policy on Automatic Deduction effective ____/____/____

3. If you have other comments, please check here ☐ and use reverse side.

Agency Name _____ **ORD code** _____

Submitted by _____ **Date** _____

NOTICE OF POTENTIAL INCOME TAX IMPLICATIONS FOR MODIFIED ENDOWMENT CONTRACTS

The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) changes the income taxation of cash withdrawn from certain affected life insurance policies called Modified Endowment Contracts, or MECs. Due to the amount of premium you plan to pay into this policy, you will be affected by this law.

It is important for you to understand that all distributions made from your policy as applied for, including policy loans, withdrawals, partial surrenders and certain dividends, will be considered to be a distribution of any gain. This means that if your policy is in a gain position when the withdrawal is made (i.e., the value of your policy exceeds the amount you've paid into it), you will owe ordinary income tax on the amount you withdraw. In addition, a 10% penalty tax is imposed by the IRS on any taxable distribution made prior to age $59\frac{1}{2}$, except on disability or if taken in the form of an annuity.

The insurance proceeds payable to your beneficiary upon the death of the Proposed Insured will continue to be income tax free under current legislation.

This notice is designed to inform you of the income taxation of life insurance based upon our understanding of the information currently available. It is not intended to provide you with legal advice, which neither John Hancock nor its Representatives can give. Therefore, if you have questions as to the applicability of any provision of the law, you should seek the advice of your own tax and legal counsel.

If you wish to modify your Planned Premiums to avoid creating a Modified Endowment Contract, your Marketing Representative will assist you. Otherwise, please sign the Acknowledgment below.

POLICYOWNER ACKNOWLEDGMENT AND SIGNATURE

I have read the above Notice of Potential Income Tax Implications. I understand that my premium payments will cause the proposed policy to become a Modified Endowment. I also understand the potential income tax effects of a distribution from a Modified Endowment.

Policyowner Signature _____ Date _____

REQUEST FOR AUTOMATIC DEDUCTION PLAN (CONTINUED)

Special Automatic Deduction Requests:

JH 0165

DETACH THIS SECTION AND GIVE TO CLIENT

JOHN HANCOCK LIFE INSURANCE COMPANY JOHN HANCOCK VARIABLE LIFE INSURANCE COMPANY

Notice to Each Person Proposed for New or Changed Coverage

As required by the Federal Fair Credit Reporting Act, we wish to advise that in connection with the insurance (or change in coverage) applied for, an investigative consumer report may be requested by the Company with respect to any person proposed for insurance or change in coverage. Such a report may contain information as to character, general reputation, personal characteristics and mode of living of such person, and is customarily obtained through personal interviews with neighbors, friends, or associates of the subject of the report. You have a right to make a written request for information as to the nature and scope of any such report under the Act by writing to us at:

John Hancock
Underwriting - Federal Fair Credit Control
P.O. Box 111 John Hancock Place
Boston, Massachusetts 02117

For identification purposes, your request must include your full name, birthdate, address, and any applicable policy number.

RECEIPT AND CONDITIONAL TEMPORARY INSURANCE AGREEMENT

- This Receipt and Conditional Temporary Insurance Agreement is governed by Agreement B of the application bearing the same number as this receipt.
- There is a **total** temporary insurance coverage limit of $250,000 on all applications pending on each person proposed for insurance with John Hancock Life Insurance Company and John Hancock Variable Life Insurance Company, regardless of the number of applications, and the face amounts of the policies applied for.

Proposed Insured _____ Application Number 9054612

Plan _____ Date _____

Received from _____ the sum of $ _____ paid with application to the Company with the same date and number as this receipt. This receipt is issued on the condition that any check, draft, or other order for the payment of money is good and can be collected.

Please make all premium checks payable to the company under which your application is being made (John Hancock Life or John Hancock Variable Life), at John Hancock Place, Boston, MA. Do not make check payable to the agent or leave the payee blank.

Conditions of Temporary Insurance Coverage. 1) The amount received must be at least the Minimum Temporary Insurance Premium, 2) Parts A and B of the application and any required medical examinations and tests must be completed, and 3) The following questions are answered "NO."

a. In the past two years, has any person proposed for insurance consulted a physician, been diagnosed with, or had treatment for heart disease, stroke, or cancer? _____

b. Has any person proposed for insurance been hospitalized within the past 6 months or been advised by a physician that he or she needs hospitalization for any reason (other than for normal pregnancy)? _____

c. Within the past 5 years has any person received counseling or treatment regarding the use of alcohol, drugs, illegal drugs, or used any illegal drug or controlled substance? _____

d. In the past 3 years has any person had a driving license suspended or revoked? _____

Commencement of Temporary Insurance Coverage. If the above Conditions of Temporary Insurance Coverage are met, coverage in accordance with the terms and conditions of the policy applied for will take effect on the latest "Completion Date" of all persons proposed for insurance. Each person's "Completion Date" will be the date of completion of the latest of the Parts A and B of the application and any medical examinations and tests required by the Company's published initial underwriting requirements, according to the age and amount applied for.

Amount of Temporary Insurance Coverage. The amount of Coverage will be the lesser of: 1) the amount applied for on each person excluding the amount payable under Option 1 of the Paid Up Insurance Rider, if applied for, unless the amount received with the application is equal to or greater than (i) the Minimum Temporary Insurance Premium plus (ii) the Lump Sum Payment shown on Page 2 (Traditional/Term) in Box I; and 2) $250,000. However, the amount of coverage will never exceed $250,000 less the total of all amounts payable under all conditional temporary insurance agreements issued by John Hancock Life Insurance Company or John Hancock Variable Life Insurance Company in connection with any insurance application pending on the Proposed Insured as of the date of this Receipt and Conditional Temporary Insurance Agreement. No benefit will be paid under this Agreement if the Proposed Insured's death results, directly or indirectly, or wholly or partially, from intentionally self-inflicted injury while sane, or self-inflicted injury while insane.

(continued on reverse)

DETACH THIS SECTION AND GIVE TO CLIENT

Information obtained about your insurability will be treated as confidential. The Company may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with procedures similar to those set forth in the Federal Fair Credit Reporting Act.

The address of the Bureau's information office is:

Medical Information Bureau
Post Office Box 105, Essex Station
Boston, Massachusetts 02112
Telephone (617) 426-3660

The Company may also release limited information in its file to other properly authorized life insurance companies to which you may apply for life or health insurance, or to which a claim for benefits may be submitted.

Information may be released to proper regulatory agencies on request and to insurance companies in connection with reinsurance.

Underwriting actions are not reported to the Bureau, nor is the Company informed through the Bureau of the underwriting actions of other companies to whom you may have applied for life or health insurance.

Receipt and Conditional Temporary Insurance Agreement (continued)

Fraud Warning. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Termination of Temporary Insurance Coverage. The conditional temporary insurance coverage provided by this Agreement will end on the earliest of:

1) The commencement of coverage under the policy issued on the basis of the application.
2) The date the Applicant refuses to accept the policy as offered for delivery.
3) The date the application is declined or deemed declined. (Policy is deemed declined if not approved within 60 days of the latest Completion Date.) Notice of any such declination will be furnished.

If termination occurs under 2) or 3) above, the amount paid will be returned on surrender of this Receipt. In no event will coverage be in effect under both this Conditional Temporary Insurance Agreement and any policy issued on the basis of the application, and any amendment thereto, with the same date and number as this Receipt and Conditional Temporary Insurance Agreement.

Commencement of Coverage Under the Policy. Coverage under any policy issued on the basis of the application will replace the coverage provided by this Agreement as of the policy Date of Issue but only if:

1) The policy is delivered to and accepted by the Applicant while all persons proposed for insurance are living and within 60 days of the latest "Completion Date," and
2) The balance of any premium required for the policy as delivered is paid while all persons proposed for insurance are living and within 60 days after the latest "Completion Date."

Minimum Temporary Insurance Premium. The Minimum Temporary Insurance Premium is one month's proportionate part of the premium according to the Company's published rates for the policy and premium interval applied for.

(check one) ☐ John Hancock Life Insurance Company
☐ John Hancock Variable Life Insurance Company

PROPOSED INSURED _____ DATE _____

MARKETING REPRESENTATIVE _____ DATE _____

(To be used in event of refund of payment)

Received of the John Hancock Life Insurance Company/John Hancock Variable Life Insurance Company (circle one) Boston, Massachusetts, the sum of $ _____.
The amount mentioned in the receipt on the reverse side hereof.

Date _____, 20 _____

JH 0167

Application to: John Hancock Life Insurance Company or John Hancock Variable Life Insurance Company

Part B-STATEMENTS TO COMPANY'S MEDICAL EXAMINER

The questions and answers in 1-10 and Details of "Yes" answers apply to the following person proposed for insurance

1. a. Person proposed for insurance: (PRINT) Bang (First Name) Lin (Middle Initial) (Last Name)

b. Birth Date (mm/dd/yy) 08 / 06 / 1969

SS# 085 / 66 / 4606

2. Ever been treated for or had any known indication of:	Yes	No
a. Disorder of eyes, ears, nose, or throat?	☐	☒
b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder?	☐	☒
c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☒
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	☐	☒
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☒
f. Sugar, albumin, blood or pus in urine, venereal disease; stone or other disorder of kidney, bladder, prostate, reproductive organs or breasts?	☐	☒
g. Diabetes; thyroid or other endocrine disorders?	☐	☒
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of muscles or bones, including spine, back, or joints?	☐	☒
i. Deformity, lameness or amputation?	☐	☒
j. Disorder of skin, lymph glands, cyst; tumor, or cancer?	☐	☒
k. Allergies, anemia or other disorder of the blood?	☐	☒
l. Alcoholism, Drug Dependence?	☐	☒
3. Within the past 5 years used amphetamines, cocaine, marijuana, narcotics, or any other drugs, except as medication prescribed by a physician?	☐	☒
4. Now under treatment or taking any prescription drug?	☐	☒
5. Any change in weight in the past year? Gain ..... lbs. Loss ..... lbs.	☐	☒
6. Other than above, within the past 5 years:		
a. Had any mental or physical disorder not listed above?	☐	☒
b. Had a checkup, consultation, illness, injury, surgery?	☒	☐
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☒
d. Had electrocardiogram, X-ray, other diagnostic test?	☐	☒
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☒
7. Ever:		
a. Had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☒
b. Requested or received a pension, benefits, or payment because of any injury, sickness or disability?	☐	☒

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

6b. James Huang, MD
340 W. Central Ave. #119
Brea, CA 92821
(714) 990-0375
Aug. 2004 – Immunization
Hep A. Vaccine.

	Yes	No
8. Have you ever been diagnosed or treated for Acquired Immune Deficiency (AIDS) or an AIDS Related Condition?	☐	☒

9. a. Name and address of your personal physician: (If none, so state)
Name James Huang, MD
Address 340 W. Central Ave. #119, Brea, CA 9282

b. In past 5 years have you consulted your personal physician for any matter not recorded in answers to questions 2-8? ☐ Yes ☒ No
If "Yes", furnish reason, details and date in "Details" space above.

10. Any family history of diabetes, cancer, high blood pressure or cholesterol, heart or kidney disease, or mental illness? ☐ Yes ☒ No

	Age If Living	Cause of Death	Age At Death
Father	72		
Mother	69		
Brothers and Sisters No. Living 4 No. Dead: 0	38 ? 45		

The foregoing statements and answers are to the best of my knowledge and belief, complete, true, and correctly recorded and are representations and not warranties.

Dated at Irvine (City or Town) CA (State) on 8-26 20 04

Witness Rena Liu RN
Medical Examiner

Signature of person proposed for insurance, if age 15 or over, or Applicant, if person proposed is under age 15.

Form 157-Combo-90

JH 0168

INSTRUCTIONS TO THE PARAMEDICAL FACILITY

1. Follow specific directions provided by this company to your Central Office.
2. Read all questions carefully and completely to the person who is to be examined if age 15 or over, otherwise to the Applicant.
3. The paramedical report even if incomplete, must be forwarded to the Agency. IT IS NOT TO BE GIVEN TO THE AGENT UNDER ANY CIRCUMSTANCES.
4. Please write or stamp your firms' name and local address on the Paramedical/Medical Examiner's Voucher located on the bottom of Part C.

PART C ☒ **PARAMEDICAL** ☐ **or** ☐ **MEDICAL EXAMINER'S REPORT**

1. (A) Is appearance unhealthy or older than stated age, or are there any obvious physical impairments? ☐ Yes ☒ No
   If yes, please explain:_____
   (B) Currently smoke cigarettes? ☐ Yes ☒ No Former Smoker? ☐ Yes ☒ No If yes, date last smoked:_____
   Smoke cigars or pipe, or use other tobacco product(s)? ☐ Yes ☒ No If yes, what products:_____
2. **MEASUREMENTS** (A) Height (in shoes) 5 ft. 8 in. (B) Weight (clothed) 170 lbs.
   (C) For males only: i. Chest circumference: Full inspiration 39 in. Forced expiration 37 in. ii. Abdomen at umbilicus 32 in.
3. **BLOOD PRESSURE** Applicant to be sitting. Take pressure in both arms. If more than 10mm. difference, repeat in both arms; otherwise repeat in either arm. If B.P. is over 135/85, record additional readings with applicant seated, after completing exam. Diastolic pressure is to be noted at disappearance of sound.

	Right Arm Systolic	Right Arm Diastolic	Left Arm Systolic	Left Arm Diastolic
1st Reading	100	60	102	60
2nd Reading				
____ Min. Later				
____ Min. Later				

4. **PULSE** 60/min. (at rest). If over 90, repeat in 5-10 min. and record ___/min.
   Any irregularities? ☐ Yes ☒ No If yes, enter number per minute_____
5. **URINALYSIS**
   (A) Was specimen done? ☒ Yes ☐ No, because ☐ client menstruating; ☐ client unable to void; ☐ other (specify)_____
   (B) Was dipstick used? ☒ Yes ☐ No If yes, results: albumin (-) sugar (-) other 0

SEND SPECIMEN TO LAB ONE (UNLESS INCLUDED IN BLOOD KIT) IF:
1. Albumin or Sugar present, or Blood Pressure over 150/100, or 2. History of Hypertension, Diabetes, Cardiovascular, or Renal disorder

   (C) Is specimen being forwarded to Lab One? ☒ Yes ☐ No
   (D) Have any medications of any type been taken in the past ten days? ☐ Yes ☒ No If yes, specify:_____
6. **OTHER STUDIES** (if required by instruction from agency or home office) ☐ Oral Fluid Kit sent to Lab One
   ☒ Blood kit sent to Lab One (please attach pink copy of authorization) ☐ Electrocardiogram attached ☐ Other studies attached: specify

THIS SECTION IS TO BE COMPLETED BY MEDICAL EXAMINERS ONLY (in addition to Sections 1-6, above)

7. HEART: Is there any: Enlargement? ☐ Yes ☐ No Dyspnea? ☐ Yes ☐ No Edema? ☐ Yes ☐ No
   Murmur(s)? ☐ Yes ☐ No (If yes, describe below; if more than one murmur, describe in separate column)

DETAILS OF "YES" ANSWERS: (please identify by number)

EXAMINATION OF THE HEART:

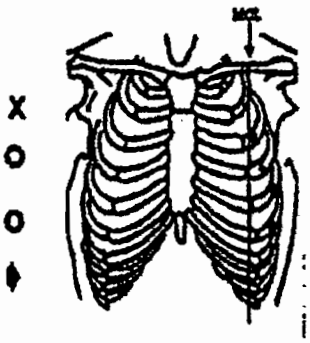
Indicate:

Apex by

Murmur area by

Point of greatest intensity by

Transmission by



For comments and your impression?

	No. 1	No. 2
Location		
Constant		
Inconstant		
Transmitted		
Localized		
Systolic		
Presystolic		
Diastolic		
Soft (Gr 1-2)		
Mod. (Gr 3-4)		
Loud (Gr 5-6)	Paramed	
After Exercise:		only
Increased		
Absent		
Unchanged		
Decreased		

8. Is there on examination any abnormality of: *(Circle applicable items and give details.)*

a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐ Yes ☐ No
b. Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	☐ Yes ☐ No
c. Nervous system (include reflexes, gait, paralysis)?	☐ Yes ☐ No
d. Respiratory system?	☐ Yes ☐ No
e. Abdomen (including scars)?	☐ Yes ☐ No
f. Genitourinary system (include prostate)?	☐ Yes ☐ No
g. Endocrine system (include thyroid and breasts)?	☐ Yes ☐ No
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	☐ Yes ☐ No
i. Are there any hernias?	☐ Yes ☐ No
j. Are you aware of or do you suspect any other medical, alcoholic, or drug history? *(A confidential report may be sent to medical director.)*	☐ Yes ☒ No

THIS SECTION IS TO BE COMPLETED BY MEDICAL EXAMINERS AND PARAMEDICAL EXAMINERS.

I certify that I personally asked each and every question and accurately recorded the answers on the Part B – Form 157. I personally performed the physical measurements and observations recorded on this page. Rena Kuo RN (Signature of person completing form.)

INSTRUCTIONS TO THE MEDICAL EXAMINER

1. The Medical Examiner must complete this form in his own handwriting. Please use black ink.
2. Read all questions carefully to the person who is to be examined if Age 15 or over, otherwise the Applicant.
3. All medical examinations, even those partially completed, must be forwarded to the Agency. THEY ARE NOT TO BE GIVEN TO THE AGENT UNDER ANY CIRCUMSTANCES.
4. Fees for examinations will be paid from the Home Office only. NO FEE IS TO BE ACCEPTED FROM AN AGENT OR ANY OTHER PERSON.

Examiner's Account No.

MEDICAL EXAMINER'S VOUCHER

To assure prompt payment of your fee this voucher should be fully completed.
(*Items to be completed by Examiner)

Amt. Of Fee

Amt. Of Ins. 1,000,000

L/B Code LDB

Reported By

Agency Name Heartland

Agency Number 128

Date of Exam: Mo. 08 Day 26 Yr. 04

Birthdate Examinee: Mo. 08 Day 06 Yr. 69

Name of Person Examined (Please Print) Bang Lin

Please Print or Type

Pay to Name ExamOne # 328

Street Address 14322 Ramona Blvd.

City or Town Baldwin Park State CA Zip Code 91706

Voucher No.

Date

TO BE COMPLETED IN EVERY CASE.

AUTHORIZATION

Date Aug. 26 20 04

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge regarding the undersigned to give to the John Hancock Life Insurance Company or its reinsurer(s) any such information, including information concerning every condition for which such person has been under observation or treatment, the history obtained, physical and laboratory findings, diagnosis and treatment.

A photostat of this authorization is as valid as the original.

Name of person proposed for insurance if under age 15 (PRINT)

Signature of person proposed for insurance, if age 15 or over, or Applicant, if person proposed for insurance is under age 15.

2004 SEP 30 PM 3:26

John Hancock Financial Services

LIFE INSURANCE SUPPLEMENTAL INFORMATION FORM

This form must be submitted with each application form 156-COMB-99 and form 156-SURV-99.

PROPOSED INSURED'S INFORMATION

1. Check the ONE choice that best describes the Proposed Insured's marital status (in case of juvenile insurance, the premium payor).
- ☐ a. Married with ONE spouse working full time for pay
- ☒ b. Married with BOTH spouses working full time for pay
- ☐ c. Retired married couple
- ☐ d. Never married
- ☐ e. Divorced
- ☐ f. Widowed
- ☐ g. Other

2. What is the approximate household income of the Proposed Insured?
- ☐ a. Less than $25,000
- ☐ b. $25,000 to $40,000
- ☐ c. $40,000 to $55,000
- ☐ d. $55,000 to $75,000
- ☐ e. $75,000 to $100,000
- ☐ f. $100,000 to $150,000
- ☒ g. More than $150,000

3. What is the approximate household income of the Policy Owner?
- ☐ a. Less than $25,000
- ☐ b. $25,000 to $40,000
- ☐ c. $40,000 to $55,000
- ☐ d. $55,000 to $75,000
- ☐ e. $75,000 to $100,000
- ☐ f. $100,000 to $150,000
- ☒ g. More than $150,000

4. What is the Net Worth of the Proposed Insured?
- ☐ a. Less than $100,000
- ☐ b. $100,000 to $250,000
- ☐ b.$250,000 to $500,000
- ☐ d. $500,000 to $1,000,000
- ☒ d. $1 million to $2 million
- ☐ e. $2 million to $5 million
- ☐ More than $5 million.

COMPLETE FOR BUSINESS INSURANCE

1. Authorized officer signing the application
Name _____ Title _____

2. Amount of business insurance already in force on Proposed Insured $ _____
3. Proposed Insured's total compensation from the business for each of the last two years:
Year _____ Compensation $ _____ Year _____ Compensation $ _____

4. Total book value of business $ _____ 5. Total market value of business $ _____

6. Year founded or incorporated _____ 7. % of business owned by Proposed Insured _____%

COMPLETE FOR ADVANCED SALES CASES

1. Does this insurance satisfy one of the estate and business needs listed below? ☐Yes ☐ No
If yes, check one **need category** and one sales concept, if applicable.

1 ☐ Estate Conservation
- a ☐ Irrevocable Trust Owned
- b ☐ Adult Children Owned

2 ☐ Business Continuation
- a ☐ Stock Redemption
- b ☐ Stock Purchase

3 ☐ Qualified Retirement Plan (Pension, Profit Sharing, 401(k), HR-10)

4 ☐ Individually Owned Insurance
- a ☐ Collateral Assignment Split Dollar
- b ☐ Executive Bonus

5 ☐ Non-Qualified Retirement Plan
- a ☐ Salary Continuation
- b ☐ True Deferral
- c ☐ Death Benefit Only
- d ☐ Severance Benefit

6 ☐ Corporate Owned Insurance
- a ☐ Endorsement Split Dollar
- b ☐ Key Person
- c ☐ Business Loan

7 ☐ Charitable Insurance

Agent's Name (print) John Fanleung Agent's Signature _____

Control Number _____ Proposed Insured(s) Bang Liu Agency _____

Form 156LISI Ed. 10/01

JH 0171

John Hancock Financial Services

LIFE INSURANCE SUPPLEMENTAL INFORMATION FORM

This form must be submitted with each application form 156-COMB-99 and form 156-SURV-99.

PROPOSED INSURED'S INFORMATION

1. Check the ONE choice that best describes the Proposed Insured's marital status (in case of juvenile insurance, the premium payor).

☐ a. Married with ONE spouse working full time for pay
☒ b. Married with BOTH spouses working full time for pay
☐ c. Retired married couple
☐ d. Never married
☐ e. Divorced
☐ f. Widowed
☐ g. Other

2. What is the approximate household income of the Proposed Insured?

☐ a. Less than $25,000 ☐ b. $25,000 to $40,000 ☐ c. $40,000 to $55,000 ☐ d. $55,000 to $75,000
☐ e. $75,000 to $100,000 ☐ f. $100,000 to $150,000 ☒ g. More than $150,000

3. What is the approximate household income of the Policy Owner?

☐ a. Less than $25,000 ☐ b. $25,000 to $40,000 ☐ c. $40,000 to $55,000 ☐ d. $55,000 to $75,000
☐ e. $75,000 to $100,000 ☒ f. $100,000 to $150,000 ☐ g. More than $150,000

4. What is the Net Worth of the Proposed Insured?

☐ a. Less than $100,000 ☐ b. $100,000 to $250,000 ☐ b.$250,000 to $500,000 ☐ d. $500,000 to $1,000,000
☒ d. $1million to $2 million ☐ e. $2 million to $5 million ☐ More than $5 million.

COMPLETE FOR BUSINESS INSURANCE

1. Authorized officer signing the application
Name_____ Title _____

2. Amount of business insurance already in force on Proposed Insured $ _____
3. Proposed Insured's total compensation from the business for each of the last two years:
Year _____Compensation $ _____ Year _____ Compensation $ _____

4. Total book value of business $_____ 5.Total market value of business $ _____

6. Year founded or incorporated _____ 7. % of business owned by Proposed Insured _____%

COMPLETE FOR ADVANCED SALES CASES

1. Does this insurance satisfy one of the estate and business needs listed below? ☐Yes ☐ No
If yes, check one **need category** and one sales concept, if applicable.

1 ☐ **Estate Conservation**
- a ☐ Irrevocable Trust Owned
- b ☐ Adult Children Owned

2 ☐ **Business Continuation**
- a ☐ Stock Redemption
- b ☐ Stock Purchase

3 ☐ **Qualified Retirement Plan (Pension, Profit Sharing, 401(k), HR-10)**

4 ☐ **Individually Owned Insurance**
- a ☐ Collateral Assignment Split Dollar
- b ☐ Executive Bonus

5 ☐ **Non-Qualified Retirement Plan**
- a ☐ Salary Continuation
- b ☐ True Deferral
- c ☐ Death Benefit Only
- d ☐ Severance Benefit

6 ☐ **Corporate Owned Insurance**
- a ☐ Endorsement Split Dollar
- b ☐ Key Person
- c ☐ Business Loan

7 ☐ **Charitable Insurance**

Agent's Name_____ Agent's Signature_____
(print)
Control Number_____ Proposed Insured(s)_____ Agency_____

Form 156LISI Ed. 10/01

JH 0172

John Hancock. Variable Life Insurance Company

AMENDMENT TO APPLICATION

Boston, Massachusetts 02117

Policy 75245678

Insured or Proposed Insured BANG LIN

(In this instrument the words "Insured" and "Policy" shall be construed to mean "Annuitant" and "Annuity Contract" if appropriate.)

It is requested that the application with respect to the above-numbered policy be amended as follows:

PAGE 1 SECTION B TO READ: JEAN LIN, WIFE, IF LIVING OTHERWISE THE INSURED' ESTATE.

PAGE 2 SECTION E PLAN OF INSURANCE TO READ: 10 YEAR LEVEL BENEFIT TERM

October 8, 2004
Agency 128
Agent No 194450

_____
Signature

174R(I)VL

JH 0173